

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
13924					CERTIFICATE OF DEATH					13929				
1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace, Md.</b>			c. LENGTH OF STAY IN lb <b>4 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>					12-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Citizens Nursing Home</b>					d. STREET ADDRESS <b>101 N. Phila. Blvd.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Knott</b> Last <b>Albaugh</b>					4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>19 67</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>September 12, 1881</b>		9. AGE (In years last birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Chester, Penna.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
13. FATHER'S NAME <b>(JOSEPH) James A. Knott</b>					14. MOTHER'S MAIDEN NAME <b>Annie M. Crowther</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>none</b>			16. SOCIAL SECURITY NO. <b>220-54-7412</b>		17. INFORMANT <b>Miss M.G. Albaugh (daughter)</b>					Address <b>Aberdeen Md</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Indefinite</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>one year</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>63</b> , to <b>10 Oct</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8 Oct</b> 19 <b>67</b> , and that death occurred at <b>9:00 A</b> M, from causes and on the date stated above.														
22a. SIGNATURE <b>John B. DeHoff</b>			M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11 Oct 67</b>							
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DEHOFF</b>			22d. ADDRESS <b>914 American Bldg Baltimore Md 21202</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			23b. DATE THEREOF <b>Oct-13-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Md 21207</b>							
24. FUNERAL DIRECTOR <b>Stewart &amp; Mowen Co 108-W-North-Av 21201</b>					25a. REC'D BY REGISTRAR <b>OCT 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							

2004

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13925

13930

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - DARLINGTON</b>		c. LENGTH OF STAY IN 1b <b>3 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DARLINGTON</b>		d. STREET ADDRESS <b>CEDAR CHURCH ROAD</b>	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	3. NAME OF DECEASED (Type or print) <b>JAMES</b>		First Middle Last <b>ANDERS</b>		4. DATE OF DEATH <b>OCTOBER 14 1967</b>		Month Day Year	
	5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 4, 1914</b>	
	9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SAW MILL OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>SPARTA, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
	13. FATHER'S NAME <b>JAMES ANDERS</b>				14. MOTHER'S MAIDEN NAME <b>FLORENCE SEXTON</b>			
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>240-20-3810</b>		17. INFORMANT <b>MRS. NINA ANDERS, DARLINGTON, MD.</b>			
	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>CORONARY ATHEROSCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS OVER 2 YEARS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>A FEW MINUTE</b> <b>OVER 2 YRS</b>	
	25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
	20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
	21. I certify that (I) (this hospital) attended the deceased from <b>MARCH</b> , 1967 to <b>OCT. 14</b> , 1967, that (I) (we) last saw the deceased alive on <b>OCT. 5</b> , 1967, and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.							
	22a. SIGNATURE <b>Philip W. Heuman</b>				22b. DATE SIGNED <b>OCT 14, 1967</b>			
	22c. PHYSICIAN'S NAME (Type) <b>PHILIP W. HEUMAN, M.D.</b>				22d. ADDRESS <b>307 HICKORY, BEL AIR, MD 21014</b>			
	23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>OCT. 17, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEL AIR GARDENS</b>		23d. LOCATION (City, town or county) _____ (State) _____ <b>BEL AIR, MD.</b>	
	24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins</b>				ADDRESS <b>DELTA, PA.</b>		25a. REC'D BY REGISTRAR <b>OCT 18 1967</b>	
					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.  
The same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
Yours truly,  
[Signature]

RECEIVED 1900  
OCT 12 1900  
1900

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13928

13931

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Showsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Showsville</u>	
c. LENGTH OF STAY IN 1b <u>59 yrs.</u>		d. STREET ADDRESS <u>Norrisville Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Farm Geo. Jones</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Shaw Badders</u>		4. DATE OF DEATH <u>October 6 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 30, 1908</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>6</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Norrisville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Smiley Badders</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Gibbs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW 2</u>		16. SOCIAL SECURITY NO. <u>215-26-5415</u>	
17. INFORMANT <u>Mrs. Mary A. Almony</u>		Address <u>RD #1 Box 253 White Hall, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>21161</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Derald P Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. A. H.</u>	
EXAMINER'S NAME (Type) <u>Gerald P Palmer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-6-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/9/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ayres Chapel</u>		23d. LOCATION (City or Town) (County) (State) <u>White Hall, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>		25a. REC'D BY REGISTRAR <u>OCT 9 1967</u>	
ADDRESS <u>Jarrettsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1933

1933

50 yrs.

ORIGINALLY FROM

1883

1883

Jan. 30, 1900

ORIGINALLY FROM

1883

1883

ORIGINALLY FROM

1883

20 of Box 257

215-26-415 Mrs. Mary A. Lundy

215-26-415

215-26-415

ORIGINALLY FROM

1883

1883

1883



1  
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<div>999</div> <div>1000</div>											
<div>13927</div> <div>13932</div>											
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgewood Arsenal</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Box 1 - Bel Air</u>					
c. LENGTH OF STAY IN 1b <u>6 days</u>						d. STREET ADDRESS <u>US Army Dispensary, Edgewood Ars. Md.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Thomas Richard</u> Middle <u>Camp Jr.</u> Last <u></u>						4. DATE OF DEATH Month <u>Oct</u> Day <u>27</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 14, 1967</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>13</u> Days <u></u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Minneapolis, Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Thomas Richard Camp Sr.</u>						14. MOTHER'S MAIDEN NAME <u>Barbara Blomker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>FCPT Norris</u>		Address <u>Edgewood Ars. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>752X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Aspiration</u> DUE TO (c) <u>Hydrocephalus - Congenital</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 month</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , to <u>1967</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>D. B. Wilmett</u>						M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 27, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Bruce Wilmett, CPT, MC</u>						22d. ADDRESS <u>US Army Dispensary, Edgewood Arsenal, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>None</u>				23b. DATE THEREOF <u>10/30/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>St. Paul, Minnesota</u>			
24. FUNERAL DIRECTOR <u>Thelma Macomber</u>						25a. REC'D BY REGISTRAR <u>NOV 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1900

Marion  
17-1-10

Infant

Infant

1900

1901

Marion  
17-1-10



13928

CERTIFICATE OF DEATH

13933

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. LENGTH OF STAY IN lb <u>Port Deposit</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizen Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>J.</u> Last <u>Campbell</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 6, 1882</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.H., Perry Point</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Charles S. Campbell</u>			
14. MOTHER'S MAIDEN NAME <u>Martha H. Donahoo</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>220-44-0592</u>				17. INFORMANT <u>Gertrude Hasson, Perryville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> DUE TO (b) <u>Cerebral Aneurysm</u> DUE TO (c) <u>Arterio Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> , 19 <u>66</u> , to <u>Oct 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 2</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Clarence I. Benson</u> M.D.				22b. DATE SIGNED <u>10/2/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson M.D.</u>	
22d. ADDRESS <u>Port Deposit, Md.</u>				22e. REC'D BY REGISTRAR <u>Lee H. Patterson &amp; Son, Perryville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-5-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee H. Patterson &amp; Son, Perryville, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 9 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

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13929

## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN lb <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>		12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>				d. STREET ADDRESS <u>1405 Balsam Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Carlisle</u> Last <u>Carlisle</u>				4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-28-1885</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>17</u> Days <u>19</u> Hours <u>67</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Columbus, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Wilson Carlisle</u>				14. MOTHER'S MAIDEN NAME <u>Ma Mae Hewitt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>269-18-7307</u>		17. INFORMANT <u>Mrs Char McDermott Forest Hill Md.</u> Address <u>1405 Balsam Place</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>old age</u> DUE TO (b) <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>lost.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A.S.C.V. D</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/30</u> , 19 <u>67</u> , to <u>10/17</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/16</u> , 19 <u>67</u> , and that death occurred at <u>4:45 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John D. Yun</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YUN</u>				22d. ADDRESS <u>HAVRE DE GRACE MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Rest</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Ohio</u>	
24. FUNERAL DIRECTOR <u>Livingston Farm Harford County Md</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 20 1967</u>							

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RECEIVED OF DEATH

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CERTIFICATE OF DEATH

13935

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS <u>12-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Allison D. Chandless</u>		4. DATE OF DEATH <u>October 6 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/1882</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Store</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Darlington, Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Wm. Chandless</u>		16. MOTHER'S MAIDEN NAME <u>Reachel Daughton</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>unk.</u>	
19. INFORMANT <u>John Hewitt</u>		Address <u>317 Fountain St. Harford, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> 4221 DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-1</u> <u>19-7</u> to <u>10-6</u> <u>19-67</u> ; that (I) (we) last saw the deceased alive on <u>10-5</u> <u>19-67</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Gerald E Palmer</u> M.D.		22b. DATE SIGNED <u>10-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gerald E Palmer MD</u>		22d. ADDRESS <u>Bol Air Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>	23b. DATE THEREOF <u>10/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darlington</u>	23d. LOCATION (City, town or county) (State) <u>Darlington, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rungrim Pm</u>		25a. REC'D BY REGISTRAR <u>10 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

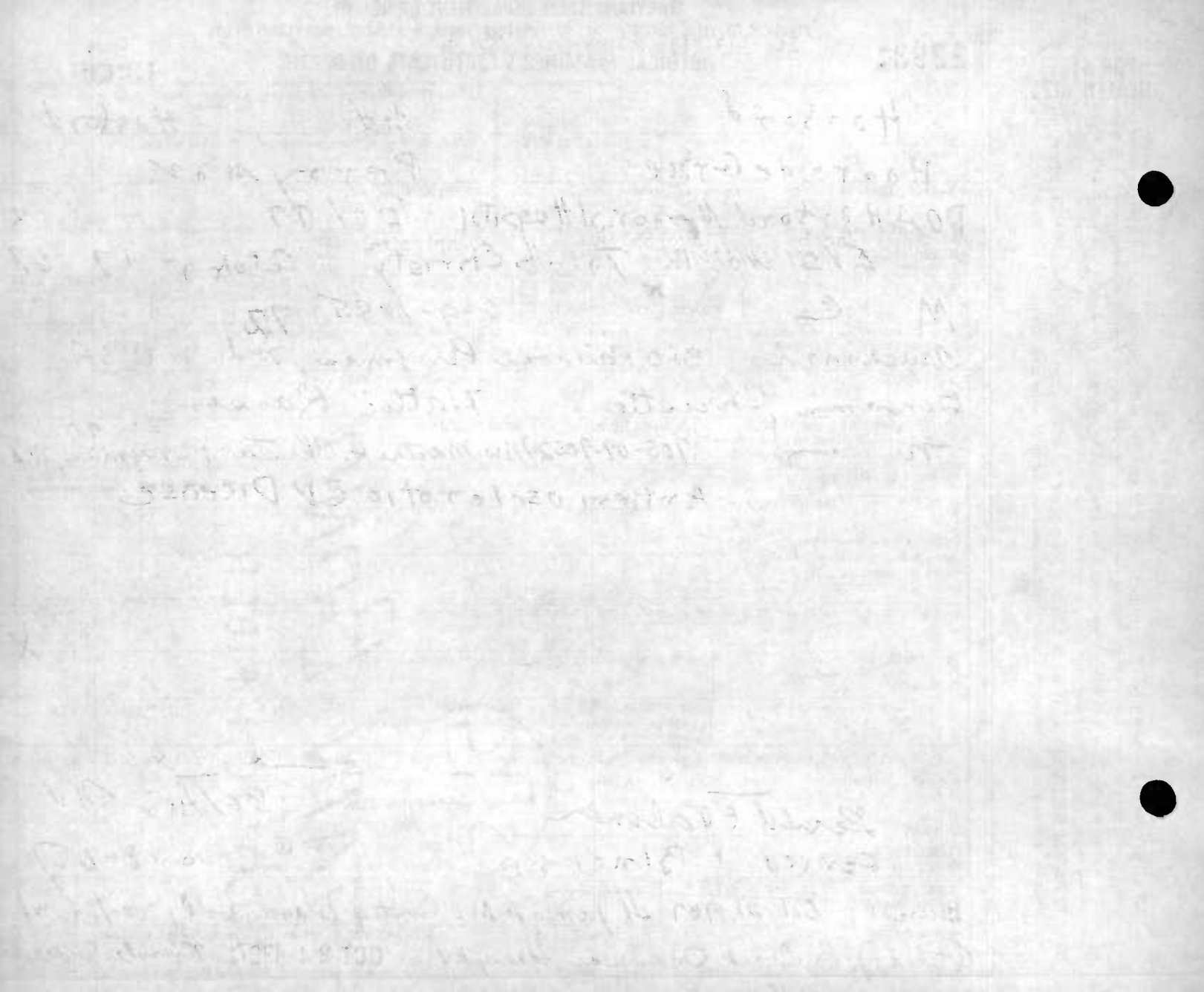
Item #3 Film #G391 10/30/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Box 77</u>	
3. NAME OF DECEASED (Type or print) <u>Jacob First Elsworth Middle Christy</u>		4. DATE OF DEATH <u>October 17 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-1895</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Perryman, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Christie</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Ransom</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-9052</u>	
17. INFORMANT <u>Mrs. Martha H. Christie</u>		Address <u>Box 77 Perryman, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4221</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dwight E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be Ar</u> <u>Md</u>	
EXAMINER'S NAME (Type) <u>Dwight E Palmer-MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-18-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 21, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. James A.M.E. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Brandy Hill, Harford, Md.</u>	
24. FUNERAL DIRECTOR <u>Atelia J. Bullock, Harre de Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cooling</u> Middle <u>Julia D.</u> Last <u>Cooling</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2 - 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>78</u> yrs.
11. BIRTHPLACE (County & state, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip</u>		14. MOTHER'S MAIDEN NAME <u>DeWeyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-12-8499</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of stomach</u> DUE TO (b) <u>Cancer of breast</u> DUE TO (c) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-5</u> , 19 <u>66</u> , to <u>10-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-11</u> , 19 <u>67</u> , and that death occurred at <u>3:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Quentin Hinch</u>		22b. DATE SIGNED <u>10-12-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Harford Chase Md</u>
24. FUNERAL DIRECTOR <u>Quinnington &amp; Son Harford Chase Md</u>		25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Quinnington &amp; Son</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13938

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At Home</b>				d. STREET ADDRESS <b>719 Warren St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>J</b> Last <b>Curen</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>22</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 14/ 1886</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>SI</b> Days <b>SI</b>		11. IF UNDER 24 HRS. Hours <b>SI</b> Min. <b>SI</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John R. Curen</b>				14. MOTHER'S MAIDEN NAME <b>Unk.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unk.</b>			
17. INFORMANT <b>Mr. John R. Curen</b>				Address <b>719 Warren St, Havre de Grace</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 4221 DUE TO <b>Cardio Vascular</b> Conditions, if any, which gave rise to immediate cause (b) <b>Cardio Vascular</b> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19....., to <b>1967</b> , 19....., that (I) (we) last saw the deceased alive on <b>9-23-19</b> , and that death occurred at <b>1967</b> , M, from the causes and on the date stated above.							
22a. SIGNATURE <b>A. L. Lewis MD</b>				22b. DATE SIGNED <b>1967</b>		22c. PHYSICIAN'S NAME (Type) <b>A. L. LEWIS MD</b>	
22d. ADDRESS <b>Havre de Grace Md</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/24/ 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Havre de Grace, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 26 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1912

DEPARTMENT OF COMMERCE

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FOR STATE HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13934

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13939

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>190 N. Main Street</u>	
3. NAME OF DECEASED (Type or print) <u>Mariam</u> First Middle Last <u>A. Dorsey</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1919</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years) <u>48</u> (In birthday) yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard W. Dorsey, Sr. (D)</u>		14. MOTHER'S MAIDEN NAME <u>Elsie P. Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Elsie Dorsey, 190 N. Main St., Port Deposit, Md.</u>		Address <u>21904</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>443x</u> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive CV Disease</u> (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <u>10-17-67</u>		23. NAME OF CEMETERY OR CREMATORY <u>Jones Memorial Cemetery</u>	
24. FUNERAL DIRECTOR <u>See A. Patterson &amp; Son, Perryville, Md.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
26. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		27. DATE THEREOF <u>Oct. 19, 1967</u>	
28. LOCATION (City or Town) (County) (State) <u>Port Deposit, Cecil, Md.</u>		29. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

13935

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13940

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Stewartstown</b>		c. LENGTH OF STAY IN 1b <b>25 Yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Stewartstown</b>		12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Isabell J. Edie</b>		4. DATE OF DEATH Month Day Year <b>10/28 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 10, 1917</b>
9. AGE (In years last birthday) yrs. <b>50</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John B. Jenkins</b>		14. MOTHER'S MAIDEN NAME <b>Lue Lue Lanus</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Paul H. Edie, Stewartstown RD#1, Pa.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO (b) <b>to Brain and Skeletal system</b> DUE TO (c) <b>Primary Breast Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>63</b> , to <b>Oct. 29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Oct. 29</b> , 19 <b>67</b> , and that death occurred at <b>7:30 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Reginald B. Gemmill</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Reginald B. Gemmill, M.D.</b>		22d. ADDRESS <b>Stewartstown, Pa.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/31/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Norrisville Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Norrisville, Harford Co., Md.</b>
24. FUNERAL DIRECTOR <b>Kenneth W. Auburn</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 31 1967</b>	
ADDRESS <b>Stewartstown, Pa.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

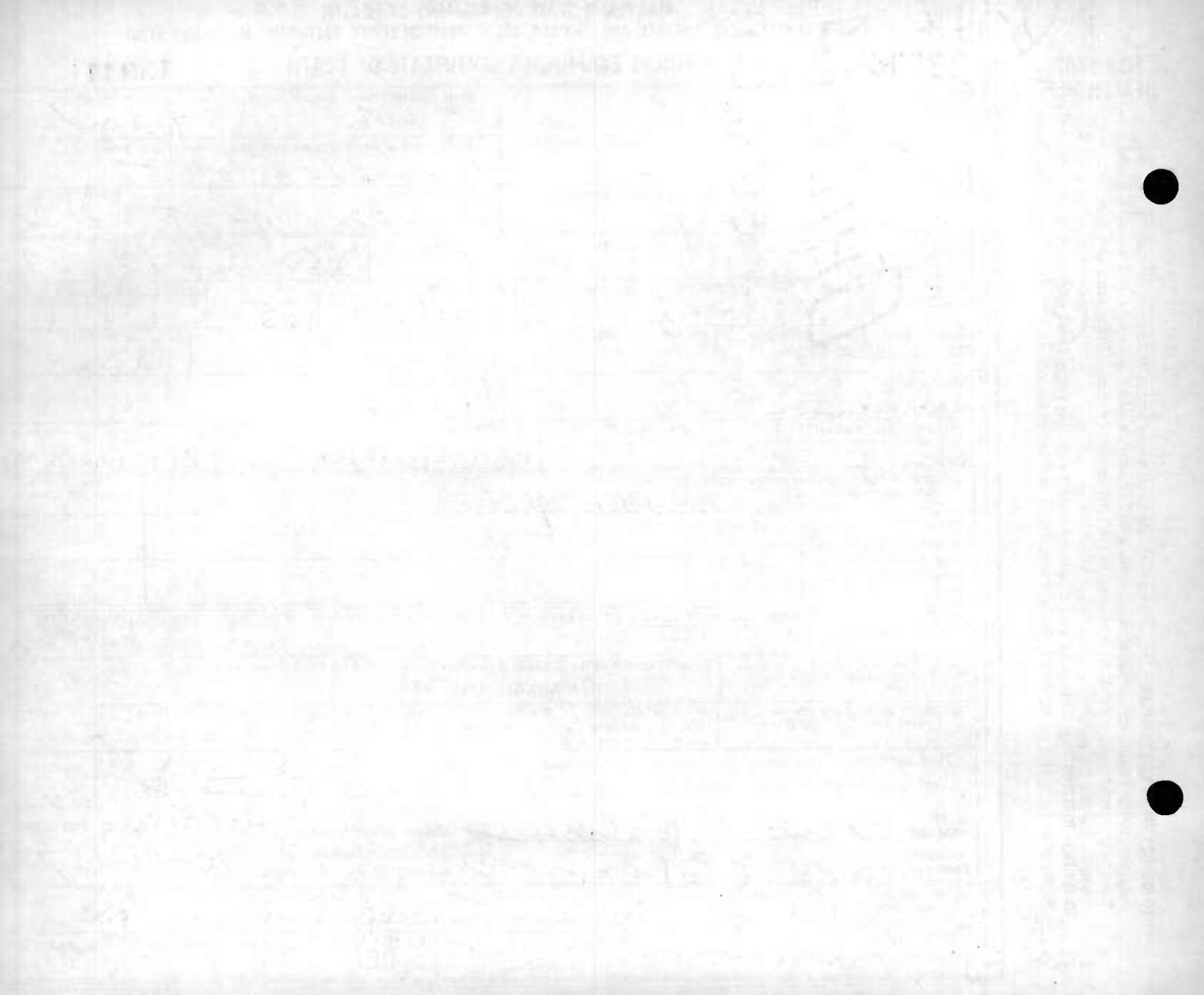
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13936

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13941

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>356 Bourbon St</u>		d. STREET ADDRESS <u>356 Bourbon St</u>	
3. NAME OF DECEASED (Type or print) <u>Ida B Freed</u>		4. DATE OF DEATH <u>October 10</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham</u>		14. MOTHER'S MAIDEN NAME <u>Elka</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>MR FELIX FREED</u>		Address <u>6600 BAYTHORNE RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>POISONING DUE TO sodium butisol</u> 970.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> (c) <u>                    </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive C V disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Took sleeping tablets</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:10</u> p.m. <u>Oct 9</u> 19 <u>67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Havre de Grace Harf. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/Air</u> <u>Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>                    </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/11/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR <u>Sylvan S. Lewis &amp; Son, Inc</u>		ADDRESS <u>Garrison Md</u>	
25a. REC'D BY REGISTRAR <u>                    </u>		25b. REGISTRAR'S SIGNATURE <u>                    </u>	
DATE <u>OCT 13 1967</u>		DATE <u>10-10-67</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13937

# CERTIFICATE OF DEATH

13942

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oberdeen</u>		d. STREET ADDRESS <u>48 Hanover</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl FRINK</u>		4. DATE OF DEATH <u>10</u> <u>8</u> <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-7-67</u> 1 day year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Richard Banks</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINE MARIE FRINK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7735</u> <u>Hyaline Membrane Disease</u> DUE TO (b) <u>7735</u> <u>Prematurity</u> DUE TO (c) <u>7735</u> <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-7, 1967</u> , to <u>10-8, 1967</u> that (I) (we) last saw the deceased alive on <u>10-8, 1967</u> , and that death occurred at <u>10:20 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>George T. Stansbury</u>		22b. DATE SIGNED <u>10/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury, M.D.</u>		22d. ADDRESS <u>569 Revolution Street</u> <u>Harre de Grace, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Harford</u> <u>Md.</u>
24. FUNERAL DIRECTOR <u>Elinor E. Bulluck</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Harre de Grace, Md.</u>		DATE <u>OCT 16 1967</u>	

1333

STATEMENT OF DEATH

1333

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Occupation		Cause of Death	
Signature of Physician		Signature of Registrar	
Date of Statement		Place of Statement	

STATE OF NEW YORK  
COUNTY OF [ ]  
I, the undersigned, being a duly qualified Registrar of Deaths for the County of [ ], do hereby certify that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the County of [ ] on the [ ] day of [ ] 19[ ].

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13943

13938

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace</u> c. LENGTH OF STAY IN 1b <u>8 hrs 30 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u> d. STREET ADDRESS <u>RFD1 Box 77-B2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Michael</u> Middle <u>Grace</u> Last <u>Grace</u> <u>Baby Boy</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 12 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years lost birthday) yrs. <u>6</u> IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS.: Hours <u>6</u> Min. <u>30</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Harford de Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Calvin D. Grace</u>		14. MOTHER'S MAIDEN NAME <u>Norma L. Howell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Calvin D. Grace</u>		Address <u>RD #1 Box 77B2 Darlington, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>7735</u> IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism</u> DUE TO (b) <u>Respiratory disease of the newborn</u> DUE TO (c) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4:25 P.M. 10-12 1967</u> , to <u>10-13 1967</u> , that (I) (we) last saw the deceased alive on <u>10-12 1967</u> , and that death occurred at <u>12:55 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Harold Brenner</u>		22b. DATE SIGNED <u>10-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD BRENNER</u>		22d. ADDRESS <u>419 S. UNION AVE HARFORD DE GRACE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/16/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Mem. Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Harford, Md.</u>
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>		25a. REC'D BY REGISTRAR <u>Jarrettsville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Kurtz</u>		DATE <u>OCT 16 1967</u>	

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David Johnson

Home

David J. Johnson

David J. Johnson

David J. Johnson

David J. Johnson

No



David J. Johnson

David J. Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

139339

CERTIFICATE OF DEATH

13944

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>8/1/67-10/16/67</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RISING SUN, MARYLAND</u>		07-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CITIZENS NURSING HOME</u>		d. STREET ADDRESS <u>16 HAMES AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY E. GRAYSON</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>16</u> Days <u>10</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJEMIAN F. RILEY</u>		14. MOTHER'S MAIDEN NAME <u>AMY KENWARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>219-20-7921</u>	
17. INFORMANT <u>1st Lt. RW</u>		Address <u>ABINGDON, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis (Cerebrovascular disease)</u> DUE TO (c) <u>Syncope</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-1</u> , 19 <u>67</u> , to <u>10-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-15</u> , 19 <u>67</u> , and that death occurred at <u>4:45</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>10/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>PORT DEPOSIT, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 19, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BROOKVIEW CEMETARY</u>		23d. LOCATION (City or Town) (County) (State) <u>RISING SUN CECIL, MD.</u>	
24. FUNERAL DIRECTOR <u>RICHARD L. GOODIE</u>		ADDRESS <u>RISING SUN, MD</u>	
25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>OCT 19 1967</u>			



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FOR STATE  
HEALTH DEPT.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13945

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill 21050</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rigdon Road, Forest Hill, Md.</b>		d. STREET ADDRESS <b>Cooptown Road, Forest Hill</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM Elwood GREENE</b>		4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/1933</b>
9. AGE (In years lost birthday) <b>34 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	
11. BIRTHPLACE (State or foreign country) <b>Madonna, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Aquilla Greene</b>		14. MOTHER'S MAIDEN NAME <b>Annie Marie Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-30-7611</b>	
17. DEATH CAUSE PART I. DEATH WAS CAUSED BY: <b>981x</b> IMMEDIATE CAUSE (a) <b>Shotgun wound of the abdomen</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot with shotgun in the abdomen</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>?</b> p.m. <b>10 8 19 67</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Uncle's yard Forest Hill Harford Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>October 9, 1967</b>	
ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>10/12/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview A.M.E.</b>	
23d. LOCATION (City or Town) <b>Forest Hill, Harford Md.</b>		23e. REGISTRAR'S SIGNATURE <b>Charles E. Kurtz</b>	
24. FUNERAL DIRECTOR <b>Charles E. Kurtz Jarrettsville, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 11 1967</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Baby Girl Hamilton</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>1</u> yrs. IF UNDER 1 YEAR If UNDER 24 HRS. Months <u>1</u> Days <u>11</u> Hours <u>11</u> Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Hartford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bob G. G. Hamilton</u>		14. MOTHER'S MAIDEN NAME <u>Versie Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Bobby G. Hamilton</u>		Address <u>Cowlingo Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cranial bleeding</u> 7544 DUE TO (b) <u>Coarctation of aorta with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>patent ductus arteriosus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-16</u> , 1967, to <u>10-16</u> , 1967, that (I) (we) last saw the deceased alive on <u>10-16</u> , 1967, and that death occurred at <u>11:30 P</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>A.B. Normant M.D.</u>		22b. DATE SIGNED <u>10.17.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.B. Normant M.D.</u>		22d. ADDRESS <u>Havre de Grace Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Bridge Baptist</u>	23d. LOCATION (City or Town) (County) (State) <u>Rising Sun Cecil Md.</u>
24. FUNERAL DIRECTOR <u>Richard L. Goodie</u>		25a. REC'D BY REGISTRAR <u>Oct 20 1967</u>	
ADDRESS <u>Rising Sun Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace</u>		c. LENGTH OF STAY in 1b <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		d. STREET ADDRESS <u>Box 532 Rt 3</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian K. Hetrick</u>		4. DATE OF DEATH <u>10 13 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 June 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>73</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Knight</u>		14. MOTHER'S MAIDEN NAME <u>Frances A. Knight</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-28-3554</u>	
17. INFORMANT <u>Miles W. Welsh,</u>		Address <u>Aberdeen, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>159X</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Carcinoma of g.i. tract exact site unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One week</u> <u>Ten months</u> <u>One year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic heart disease - Diabetes mellitus latent</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>99-11-61</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-12-1967</u> to <u>10-13-1967</u> , that (I) (we) last saw the deceased alive on <u>10-12-1967</u> , and that death occurred at <u>9A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Peter P. Rodman</u>		22b. DATE SIGNED <u>10-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		22d. ADDRESS <u>8 Law St., Aberdeen, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>16 Oct. 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Aberdeen Harford Md.</u>	
24. FUNERAL DIRECTOR <u>Tarring &amp; Tarring</u>		ADDRESS <u>Tarring Funeral Home, Aberdeen, Md.</u>	
25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







13943

CERTIFICATE OF DEATH

13948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
c. LENGTH OF STAY IN lb <u>D.O.A.</u>		d. STREET ADDRESS <u>1309 Herbert Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine T. Hunt</u>		4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-11-1930</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Good Handler Copatini</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Indiana, Miss.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>George Culpepper</u>	
14. MOTHER'S MAIDEN NAME <u>Naomi Jordan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>242-38-9303</u>		17. INFORMANT <u>Mr. Matthew H. Hunt, Joppa, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Oct 26</u> , 19 <u>67</u> , to <u>Oct 26</u> , 1967, that (I) (we) last saw the deceased alive on <u>Oct 26</u> , 1967, and that death occurred at <u>5 A.M.</u> from causes and on the date stated above.	
22a. SIGNATURE <u>George T. Stansbury</u>		22b. DATE SIGNED <u>10/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		22d. ADDRESS <u>569 Revolution St. Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 30, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Community Baptist Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Joppa, Harford, Md.</u>	
24. FUNERAL DIRECTOR <u>Otelia J. Bullock, Havre de Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1931

CERTIFICATE OF DEATH

1931

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

1. Name of deceased: [illegible]		2. Sex: [illegible]		3. Age: [illegible]	
4. Date of birth: [illegible]		5. Date of death: [illegible]		6. Place of death: [illegible]	
7. Cause of death: [illegible]		8. Signature of physician: [illegible]		9. Signature of registrar: [illegible]	
10. Date of registration: [illegible]		11. [illegible]		12. [illegible]	

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98. [illegible]  
99. [illegible]  
100. [illegible]

13944

## CERTIFICATE OF DEATH

13949

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY in 1b <u>6 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>553 Revolution St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u>		4. DATE OF DEATH <u>October 12 1967</u>		5. SEX <u>M</u>	
6. COLOR OR RACE <u>CE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 23, 1895</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unk.</u>		14. MOTHER'S MAIDEN NAME <u>Lena Jenkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>202-09-8654</u>		17. INFORMANT <u>Mrs. Gertrude L. H. Jenkins, Harre de Grace, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>AUTO STATIC HYPOTENSION</u> DUE TO (c) <u></u>		19. INTERVAL BETWEEN ONSET AND DEATH		20. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>POST OPERATIVE PROSTATECTOMY.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20c. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Oct 6, 1967</u> to <u>Oct 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>10/12 1967</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>W. A. Council, Jr.</u>		22b. DATE SIGNED <u>10/13/67</u>		22c. PHYSICIAN'S NAME (Type) <u>W. A. Council, Jr.</u>	
22d. ADDRESS <u>611 So. UNION AVE HARRE DE GRACE, MD.</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE <u>OCT 16 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Oct. 17, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Marion G. Thomas Funeral Home</u>	
23d. LOCATION (City or Town) (County) (State) <u>Cumberland Va.</u>		23e. REC'D BY REGISTRAR <u>Charles Judge</u>		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR <u>Otelia J. Bullock, Harre de Grace, Md. 21078</u>		24a. ADDRESS <u>556 Xenia St.</u>		24b. DATE <u>OCT 16 1967</u>	

6421

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13945  
Item #3 Film #0394 11/13/67 pp  
13950  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Darlington</b> c. LENGTH OF STAY IN 1b <b>51 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Darlington</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Virginia</b> Last <b>Knight</b>		4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1916</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Harford Co., Md.</b>
13. FATHER'S NAME <b>Samuel M. Orr</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>162-05-9414</b>	
17. INFORMANT <b>Kloman Knight, Darlington, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism ?</b> 463X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Phlebothrombosis, rt. leg / ?</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>2 weeks.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 24</b> , 19 <b>66</b> , to <b>Oct. 28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Oct. 17</b> , 19 <b>67</b> , and that death occurred at <b>11A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert Barthel</b>		22b. DATE SIGNED <b>Oct. 28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert Barthel M.D.</b>		22d. ADDRESS <b>Box #4, Forest Hill, Md., 21050</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 31, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Broad Creek Friends Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Street, Harford Co., Md.</b>
24. FUNERAL DIRECTOR <b>John H. Hawkins</b>		25a. REC'D BY REGISTRAR <b>NOV 1 1967</b>	
ADDRESS <b>Delta, Pa.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1930

Barford

Robert Barford

21 years

Barford - Barford

October 26

Barford

Barford

Barford

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Barford

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Barford

Oct 26

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Oct 26

Box 40, Green Hill, N.C., 27030

Robert Barford



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13946

13951

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Have de Grace</i>		c. LENGTH OF STAY IN 1b <i>21 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Have de Grace</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>848 Otisco St</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>Libeastroce</i> Last <i>Libeastroce</i>		4. DATE OF DEATH Month <i>October</i> Day <i>11</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>11/9/1900</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	9. AGE (In years last birthday) <i>67</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTH PLACE (County & State, or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Decedent</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unk.</i>	
17. INFORMANT <i>Dr. Puzoski Libeastroce</i>		Address <i>848 Otisco St. Harford, Md 21078</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> DUE TO (b) <i>Arteriosclerotic Heart disease</i> DUE TO (c) <i>Uremia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>4 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Tumor abdomen awaiting histo logical diag.</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital), attended the deceased from <i>9/18</i> , 19 <i>67</i> , to <i>10/11/67</i> , that (I) (we) last saw the deceased alive on <i>Oct 11</i> , 19 <i>67</i> , and that death occurred at <i>11:50</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Chm. W. J. J. J.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>10/11/67</i>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>10/14/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Ann's</i>	23d. LOCATION (City or Town) (County) (State) <i>Harford Md</i>
24. FUNERAL DIRECTOR <i>Funerary Rm. Harford Md</i>		25a. REC'D BY REGISTRAR <i>OCT 16 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1921

CERTIFICATE OF EXPORT

1921

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*Artocarpus lacucha*  
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*Artocarpus lacucha*

CERTIFICATE OF DEATH

13952

13947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>—</u> Middle <u>—</u> Last <u>M<sup>c</sup>Mullen</u>				4. DATE OF DEATH <u>October 24</u> 19 <u>67</u> Month <u>October</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-24-1877</u> 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mech. Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William - McMullen Sr.</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE SMeltzer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-14-989</u>		17. INFORMANT <u>Mrs. W<sup>m</sup> McMullen</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalized</u> DUE TO (b) <u>Arteriosclerosis Heart disease</u> DUE TO (c) <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> , 19 <u>67</u> , to <u>10-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-24</u> , 19 <u>67</u> and that death occurred at <u>1:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Irwin L. Weehman</u> M.D.				22b. DATE SIGNED <u>10/24/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Irwin L. Weehman</u>	
22d. ADDRESS <u>HAURE DE GRACE Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-27-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Port Deposit Cecil Md.</u>	
24. FUNERAL DIRECTOR <u>Leon E. Mullen</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1942

OFFICE OF DEATH

1942

Name of Deceased		Date of Death	
John Doe		12-25-42	
Age		35	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Student	
Cause of Death		Suicide	
Place of Death		New York City	
Time of Death		10:00 PM	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

It is hereby certified that the above is a true and correct copy of the original record of the death of John Doe, as the same appears from the records of the Office of the Registrar of Deaths, New York City, for the year 1942.

W. J. [Signature]  
Registrar of Deaths

13948

CERTIFICATE OF DEATH

13953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Route #2, Box 138</u>	
3. NAME OF DECEASED (Type or print) <u>Wilson R</u>		4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 Oct. 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>	9. AGE (In years last birthday) <u>78</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Harford County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Bryson Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Alice Virginia Wakeland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-I</u>		16. SOCIAL SECURITY NO. <u>213-36-7528</u>	
17. INFORMANT <u>Wife, Same as 2 C &amp; D.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arterio-Sclerosis - Hypertension</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19-42</u> , 19____ to _____, 19____, that (I) (we) last saw the deceased alive on <u>10-2-67</u> , and that death occurred at <u>7:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E. L. Lewis MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN NAME (Type) <u>A. L. LEWIS</u>		22d. ADDRESS <u>Harford Grace Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9 Oct. 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Meth. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Churchville, Maryland</u>
24. FUNERAL DIRECTOR <u>Norm B. Tarrington</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



2433



CERTIFICATE OF DEATH

13848

13854

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY in lb <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>				d. STREET ADDRESS <u>Rd 2</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Henry</u> Last <u>Monk</u>				4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-1-1880</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret own farm</u>		11. BIRTHPLACE (County & State for foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Lafayette Monk</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Lytton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-52-2892</u>		17. INFORMANT <u>Mrs Martha Monk the Rising Sun Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>advanced ASCVD</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-7</u> , 19 <u>67</u> to <u>10-13</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/13/67</u> 19 <u>67</u> , and that death occurred at <u>8 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>CW Grigoleit</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. GRIGOLEIT</u>				22d. ADDRESS <u>Harre de Grace</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-16-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Port Deposit Cecil Md.</u>	
24. FUNERAL DIRECTOR <u>James McShullen</u>				ADDRESS <u>Rising Sun, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 17 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
13955			
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		d. STREET ADDRESS <u>709 Elkton Blvd</u>	
3. NAME OF DECEASED (Type or print) <u>Walter E. Montgomery</u>		4. DATE OF DEATH <u>10 2 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Harry Stern Montgomery</u>		14. MOTHER'S MAIDEN NAME <u>Florence Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>200-10-4234</u>	
17. INFORMANT <u>Mrs. Cecile E. Montgomery, Elkton, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 Ventricular fibrillation</u> DUE TO <u>Chronic Cardiac Decompensation, 2 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>A.S.C.V.D.</u> (b) <u>2 years.</u> (c) <u>2 years.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension, under controlled</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/23, 1967</u> to <u>10-2, 1967</u> , that (I) (we) lost the deceased alive on <u>10/2, 1967</u> , and that death occurred at <u>9:22 M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>10/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Haure de Grace, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/5/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Pres. Cemetery, Colora, Md.</u>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 9 1967</u>			

12/10/50

STATE OF TEXAS

12/10/50

12/10/50

12/10/50

12/10/50

12/10/50

12/10/50

12/10/50

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13951

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13956

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. LENGTH OF STAY IN lb <u>04</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delta</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>Box 27</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>John</u> Middle <u>Neilon</u> Last <u>Joseph John Neilon</u>				4. DATE OF DEATH <u>October 28</u> 19 <u>67</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1933</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Joseph G. Neilon</u>				14. MOTHER'S MAIDEN NAME <u>Nora Powers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Korean Con.</u>		16. SOCIAL SECURITY NO. <u>209-26-1380</u>		17. INFORMANT <u>Hartford Mem. Hospital</u> Address <u>Hartford de Grace, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Open Fracture Skull</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>					
20c. TIME OF INJURY Month, Day, Year <u>2</u> <u>10</u> <u>10-28</u> 19 <u>67</u> <u>4</u> <u>p.m.</u>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Whiteford</u> <u>Hd</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. A. M.</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-28-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Nov. 2, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	
23d. LOCATION (City or town) (County) (State) <u>Heaton, Delaware Co., Penna.</u>				23e. REC'D BY REGISTRAR <u>NOV 2 1967</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1883

THE  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON  
D. C.

NOV 10 1883

TO THE  
HONORABLE  
MEMBERS OF THE  
NAVY

THE  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 11-66

CERTIFICATE OF DEATH

13954

13958

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN lb <u>31 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>	
3. NAME OF DECEASED (Type or print) <u>BEVERLY ANNETTE OWEN</u>		d. STREET ADDRESS <u>107 PARKWAY AVE</u>	
3. NAME OF DECEASED (Type or print) <u>BEVERLY ANNETTE OWEN</u>		4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years lost birthday) yrs. <u>—</u>
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>STEPHEN EARL OWENS</u>		14. MOTHER'S MAIDEN NAME <u>CARROLL ANN WALKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>STEPHEN E. OWEN</u>		Address <u>HAVERDE GRACE MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO (b) <u>prematurity</u> DUE TO (c) <u>Premature Separation Placenta</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 28, 1967</u> to <u>Oct 29, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct 29, 1967</u> , and that death occurred at <u>12:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Wm H. W. Brown</u> M.D.		22b. DATE SIGNED <u>10/29/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Oct 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>HAVERDE GRACE HARFORD MD.</u>
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 31 1967</u>	
ADDRESS <u>HAVERDE GRACE MD.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

7-252402



13953

## CERTIFICATE OF DEATH

13959

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferryville</u>	
c. LENGTH OF STAY IN 1b <u>10 hrs.</u>		d. STREET ADDRESS <u>River Rd Box 425</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha Mae Owens</u>		4. DATE OF DEATH <u>10 27 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-1904</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>4</u> Hours <u>4</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ben Ross</u>		14. MOTHER'S MAIDEN NAME <u>Ida Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Betty h. Dagg</u>		Address <u>Ferryville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage</u> DUE TO (b) <u>Perforated ulcer + Peritonitis</u> DUE TO (c) <u>Ac. Peptic ulcer</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 27, 1967</u> , to <u>Oct 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 27, 1967</u> , and that death occurred at <u>9:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. D. Hirsch</u>		22b. DATE SIGNED <u>10-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u>		22d. ADDRESS <u>131 S. Union Ave, Harre-de-Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/30/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellin Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bellin Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. G. Patterson &amp; Son, Ferryville, Md.</u>		25a. REC'D BY REGISTRAR <u>Nov 2 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>John Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLATE 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR A15 (4)  
20 M 1/66

13952

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film G198 2/29/68 W

# CERTIFICATE OF DEATH

13957

1. PLACE OF DEATH a. COUNTY <b>Hafford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Hafford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Citizen Nursing Home, 415 S. Market St.</b>		d. STREET ADDRESS <b>Port Deposit, Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>B.</b> Last <b>Owens Owens</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>15</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03-28-1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edwin L. Craig</b>		14. MOTHER'S MAIDEN NAME <b>Sarah L. Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Ruth O. Knauss, Port Deposit, Maryland.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Sclerosis</b> DUE TO (b) <b>Arterio Sclerosis -</b> DUE TO (c) <b>Hypertension, Tissue Necrosis -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months 6 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension, Tissue Necrosis -</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 14</b> , 19 <b>67</b> , to <b>Oct 14</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>Oct 14</b> , 19 <b>67</b> , and that death occurred at <b>930</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>Clarence I. Benson</b> M.D.		22b. DATE SIGNED <b>10/15/67.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clarence I. Benson M.D.</b>		22d. ADDRESS <b>Port Deposit, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-18-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Principio Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Perryville, Md.</b>	
24. FUNERAL DIRECTOR <b>Lee A. Patterson &amp; Son,</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 23 1967</b>	



1955

STATE OF CALIFORNIA

1955

1. Name of the person or entity		2. Address	
3. City		4. State	
5. Zip		6. Date	
7. Signature		8. Title	
9. Printed Name		10. Address	
11. City		12. State	
13. Zip		14. Date	
15. Signature		16. Title	
17. Printed Name		18. Address	
19. City		20. State	
21. Zip		22. Date	
23. Signature		24. Title	
25. Printed Name		26. Address	
27. City		28. State	
29. Zip		30. Date	
31. Signature		32. Title	
33. Printed Name		34. Address	
35. City		36. State	
37. Zip		38. Date	
39. Signature		40. Title	
41. Printed Name		42. Address	
43. City		44. State	
45. Zip		46. Date	
47. Signature		48. Title	
49. Printed Name		50. Address	
51. City		52. State	
53. Zip		54. Date	
55. Signature		56. Title	
57. Printed Name		58. Address	
59. City		60. State	
61. Zip		62. Date	
63. Signature		64. Title	
65. Printed Name		66. Address	
67. City		68. State	
69. Zip		70. Date	
71. Signature		72. Title	
73. Printed Name		74. Address	
75. City		76. State	
77. Zip		78. Date	
79. Signature		80. Title	
81. Printed Name		82. Address	
83. City		84. State	
85. Zip		86. Date	
87. Signature		88. Title	
89. Printed Name		90. Address	
91. City		92. State	
93. Zip		94. Date	
95. Signature		96. Title	
97. Printed Name		98. Address	
99. City		100. State	
101. Zip		102. Date	
103. Signature		104. Title	
105. Printed Name		106. Address	
107. City		108. State	
109. Zip		110. Date	
111. Signature		112. Title	
113. Printed Name		114. Address	
115. City		116. State	
117. Zip		118. Date	
119. Signature		120. Title	
121. Printed Name		122. Address	
123. City		124. State	
125. Zip		126. Date	
127. Signature		128. Title	
129. Printed Name		130. Address	
131. City		132. State	
133. Zip		134. Date	
135. Signature		136. Title	
137. Printed Name		138. Address	
139. City		140. State	
141. Zip		142. Date	
143. Signature		144. Title	
145. Printed Name		146. Address	
147. City		148. State	
149. Zip		150. Date	
151. Signature		152. Title	
153. Printed Name		154. Address	
155. City		156. State	
157. Zip		158. Date	
159. Signature		160. Title	
161. Printed Name		162. Address	
163. City		164. State	
165. Zip		166. Date	
167. Signature		168. Title	
169. Printed Name		170. Address	
171. City		172. State	
173. Zip		174. Date	
175. Signature		176. Title	
177. Printed Name		178. Address	
179. City		180. State	
181. Zip		182. Date	
183. Signature		184. Title	
185. Printed Name		186. Address	
187. City		188. State	
189. Zip		190. Date	
191. Signature		192. Title	
193. Printed Name		194. Address	
195. City		196. State	
197. Zip		198. Date	
199. Signature		200. Title	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13955

13960

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route #1</b>		d. STREET ADDRESS <b>Route #1, Box 228-D</b>	
3. NAME OF DECEASED (Type or print) First <b>JANE</b> Middle <b>ELIZABETH</b> Last <b>PHILLIPS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1886</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Crawford Co., Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>D.M. Clawson</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Croskey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-14-4286</b>	
17. INFORMANT <b>Ruby Register, Aberdeen, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>Pneumonia, Hypostatic</b> DUE TO (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>6 1/2 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-11-</b> 19 <b>67</b> , to <b>10-9-</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-24-</b> 19 <b>67</b> , and that death occurred <b>9:00 PM</b> from causes and on the date stated above.		22a. SIGNATURE <b>Peter P. Rodman, M.D.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>		22b. DATE SIGNED <b>10-10-67</b>	
22d. ADDRESS <b>8 Law St. Aberdeen, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/12/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bakers Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Aberdeen, Maryland</b>	
24. FUNERAL DIRECTOR <b>Walter Macomber Sr.</b>		25a. REC'D BY REGISTRAR <b>OCT 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12855

STATE OF NEW YORK

1911

REPORT

ANNUAL REPORT

OF THE

COMMISSIONER OF

THE LAND OFFICE

FOR THE YEAR

1911

1911-12

ALBANY

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## CERTIFICATE OF DEATH

13961

13956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>420 Doris Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Piper</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5, 1924</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor-ESSD.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. APG.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Jennerstown, Penna.</u>			
13. FATHER'S NAME <u>Harry Piper (D)</u>				14. MOTHER'S MAIDEN NAME <u>Beulah Mitchell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-II</u>		16. SOCIAL SECURITY NO. <u>193-18-2021</u>		17. INFORMANT Address <u>Dorothy B. Piper, Aberdeen, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4-6 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 14, 1967</u> to <u>Oct 16, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct 16, 1967</u> , and that death occurred at <u>1235</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Dudley Phillips</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>				22d. ADDRESS <u>DARLINGTON MD 21034</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>19 Oct. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Gardens, Aberdeen, Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Walter Newcomer Jr.</u>				25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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## CERTIFICATE OF DEATH

13962

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville Rural</u> <u>07-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HANNAH</u> First <u>Fulton</u> Middle <u>Reed</u> Last				4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1880</u>		9. AGE (In years last birthday) yrs. <u>87</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Archibald S. Reed</u>				14. MOTHER'S MAIDEN NAME <u>Sara Fulton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs. Rebecca Pinto, Newark, Del.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>A.S.C.U.D</u> DUE TO (c) <u>old age</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>Oct 29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-29</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> M., from causes on and on the date stated above.							
22a. SIGNATURE <u>John D. Yun</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YUN</u>				22d. ADDRESS <u>Havre de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Salem Meth. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Wilmington, Del.</u>	
24. FUNERAL DIRECTOR <u>Ree A. Patterson &amp; Son</u>				ADDRESS <u>Perryville, Md. 21903</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 2 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Hartford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Hartford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Haver-de-Grace</i>				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hartford Memorial Hospital</i>				d. STREET ADDRESS <i>508 Revolution St.</i>			
3. NAME OF DECEASED (Type or print) <i>Andrew Archer Rice</i>				4. DATE OF DEATH Month <i>10</i> Day <i>11</i> Year <i>1967</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 3, 1889</i>	9. AGE (In years last birthday) <i>78 yrs.</i>	IF UNDER 1 YEAR Months <i>2</i> Days <i>8</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Abraham Perryman, Md</i>		11. BIRTHPLACE (County & State, or foreign country) <i>U.S.A</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Abraham Rice</i>				14. MOTHER'S MAIDEN NAME <i>Georganna Lissow</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>705-09-9071</i>		17. INFORMANT <i>Mr. William Rice</i> Address <i>508 Revolution Street Haver-de-Grace, Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO (b) <i></i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Transient Essential Hypertension</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7/7</i> , 19 <i>67</i> , to <i>10/11</i> , 1967, that (I) (we) last saw the deceased alive on <i>10/10</i> , 1967, and that death occurred at <i>6:55 P.M.</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>George T. Stansbury</i>				22b. DATE SIGNED <i>10/11/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>				22d. ADDRESS <i>569 Revolution St Haver-de-Grace, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-16-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Abertown Hartford Md</i>	
24. FUNERAL DIRECTOR <i>Elmer E. Bulluck</i>				25a. REC'D BY REGISTRAR DATE <i>OCT 16 1967</i>		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>	

223

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CERTIFICATE OF DEATH

13964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - DARLINGTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>				d. STREET ADDRESS <u>R.D. #1 Box 68A</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>M.</u> Last <u>Rowan</u>				4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-14-03</u>		9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>DUBLIN, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN ORR</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN LITTLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-28-6729</u>		17. INFORMANT <u>Mrs Anita Townsley Atkinson</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of the colon</u> DUE TO (b) <u>metastases</u> DUE TO (c) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumo pneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>11:00</u> P.M. from causes on and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>OCT. 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>I. LAJOS MEZEI</u>		22d. ADDRESS <u>MID HARFORD DE GRACE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>		23d. LOCATION (City or Town) (County) (State) <u>DARLINGTON, MD.</u>	
24. FUNERAL DIRECTOR <u>John B. Harkins, DELTA, PA.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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13965

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>		c. LENGTH OF STAY IN 1b <u>14 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Austin Singleton</u>		4. DATE OF DEATH <u>October 28</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-10</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>	
11. BIRTHPLACE (State or foreign country) <u>York Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Russell Singleton</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Harmon</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-09-2679</u>	
17. INFORMANT <u>Mrs. Grace C. Singleton, Whiteford, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Coronary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer, MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-30-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air Harford Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John H. Harkins</u> ADDRESS <u>Delta, Pa.</u>		25a. REC'D BY REGISTRAR <u>NOV 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

Handwritten notes and diagrams, including a large circular diagram on the right side of the page.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

13961

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13966

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>355 Lewis St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia Smith</u>		4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-08</u> AGE (In years last birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Metal Cabinets</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
13. FATHER'S NAME <u>Oran D Smith</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Judy G. Smith</u>		Address <u>355 Lewis St. Hartford de Grace MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GSR Chest</u> DUE TO <u>976x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> DUE TO (c) <u>                    </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>2</u> Hour a.m. <u>10-18</u> 19 <u>67</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Hartford de Grace</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dorinda C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dorinda C Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <u>10-18-67</u>	
23a. BURIAL, CREMATION, or DISPOSAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ramsay Indiana</u>	
24. FUNERAL DIRECTOR <u>Livingston R. Harrell</u>		25a. REC'D BY REGISTRAR <u>Charles Jones</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

OCT 20 1967



13962

CERTIFICATE OF DEATH

13962

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GRANVILLE HAROLD SPENCER</b>		4. DATE OF DEATH Month Day Year <b>October 31st 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1912</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Glenn L. Martin</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Granville Spencer</b>	
14. MOTHER'S MAIDEN NAME <b>Polly Ann Walton</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wm. I. Spencer, Box 56, Fallston, Md. 21047</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> DUE TO (b) <b>MASSIVE CORONARY OCCLUSION</b> DUE TO (c) <b>CORONARY ARTERY DISEASE (CORONARY Atherosclerosis) Feb 67</b>		INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>IMMEDIATE</b> <b>7 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1951</b> , 19 <b>19</b> to <b>31 Oct</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>31 Oct</b> 19 <b>67</b> , and that death occurred at <b>3:00 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Harvey P. Sidwell</b>		22b. DATE SIGNED <b>11/3/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harvey P. Sidwell, MD</b>		22d. ADDRESS <b>Bel Air, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/3/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Bel Air, Harford Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Walter McCombs Jr.</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 6 1967</b>	
ADDRESS <b>Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15383

EXHIBIT OF DEATH

15383

Full name

Full name

2

1912

John and Walter

CRACK RESPIRATORY FAILURE

MASSIVE BRONCHIAL COLLAPSE

COLONIAL MYXOMA DISEASE (commonly known as) THIS

Henry R. H. H. H.

11/13/12

John and Walter

11/13/12

11/13/12

FOR STATE  
HEALTH DEPT.

13963

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13968

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hagerwood</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bush River</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David Lamar Spiker</u>		4. DATE OF DEATH <u>October 19 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 25 1949</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Aden J. Spiker</u>		14. MOTHER'S MAIDEN NAME <u>Cora C. Cloninger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>243-82 7746</u>	
17. INFORMANT <u>Aden J. Spiker</u>		Address <u>2908 Hilldale Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to Drowning</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Boat capsized</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:30 PM 10-14-67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bush River</u>		20f. (City or town) <u>Hagerwood</u> (County) <u>Md</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		Address (Street, city, town, or county) <u>Baltimore Md</u>	
23a. 8 BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 15 - 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City or Town) <u>Baltimore</u> (County) <u>Md</u> (State) <u>Md</u>
24. FUNERAL DIRECTOR <u>Ellsworth Arment</u>		ADDRESS <u>4600 Liberty Hgts Baltimore Md</u>	
25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10000

STATE OF NEW YORK

10000



8





**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO DEPUTY MEDICAL EXAMINER:**

VR A15ME 15  
6M 1/66 U

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13964

13905

1. PLACE OF DEATH o. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		d. STREET ADDRESS <b>34 W. Bel Air Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNIE M. YARNELL TARRING</b>		4. DATE OF DEATH Month Day Year <b>October 2, 19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 17-1886</b>	9. AGE (In years past birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Perryman, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jasper Peter Yarnell</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Malcolm</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-44408</b>		17. INFORMANT Address <b>H. Willard Tarring, Aberdeen, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of Femur</b> <b>903.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall on street</b>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>May 19 67</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Union Ave</b>	
20f. (City or town) <b>Havre de Grace, Md.</b>		20g. (County) <b>Harford</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Gerald C. Palmer</b>		EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>		22. DATE SIGNED <b>Bel Air, Md. 190-3-C</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5 Oct 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spesutia Cemetery</b>	
23d. LOCATION (City or Town) <b>Perryman, Harford Md.</b>		23e. (County) <b>Harford</b>		23f. (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Tarring Funeral Home</b>		25a. REC'D BY REGISTRAR <b>OCT 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. J.</b>	
26. ADDRESS <b>Aberdeen, Md.</b>					

RECEIVED  
JAN 10 1951  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO: DIRECTOR, BUREAU OF PLANT INDUSTRY  
FROM: [illegible]  
SUBJECT: [illegible]

RE: [illegible]  
[illegible]  
[illegible]

DATE: [illegible]  
[illegible]  
[illegible]

BY: [illegible]  
[illegible]  
[illegible]

APPROVED: [illegible]  
[illegible]  
[illegible]

SPECIAL AGENT IN CHARGE  
[illegible]  
[illegible]

FOR THE DIRECTOR  
[illegible]  
[illegible]

RECEIVED  
JAN 10 1951  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO: DIRECTOR, BUREAU OF PLANT INDUSTRY  
FROM: [illegible]  
SUBJECT: [illegible]

## CERTIFICATE OF DEATH

13970

13965

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>34 W. Bel Air Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Willard</u> Last <u>Tarring</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 Dec. 1877</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>15</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret) <u>Broker &amp; Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canned Goods</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Aberdeen, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Tarring</u> Brokerage				14. MOTHER'S MAIDEN NAME <u>Hannah Elizabeth Greenland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-4940</u>		17. INFORMANT <u>Henry Tarring Jr. Havre de Grace, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Cerebral atherosclerosis</u> DUE TO (c) <u>Chronic urinary tract infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>&gt; 10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic urinary tract infection</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>62</u> , to <u>Oct 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct. 15</u> , 19 <u>67</u> , and that death occurred at <u>1:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>B.J. Plunkett Jr.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-15-77</u>			
22c. PHYSICIAN'S NAME (Type) <u>B.J. Plunkett Jr.</u>		M.D.		22d. ADDRESS <u>W. Bel Air Ave. Aberdeen, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>18 Oct. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Perryman (Harford) Md.</u>	
24. FUNERAL DIRECTOR <u>Charles Macomber Sr.</u>		ADDRESS <u>Tarring General Home</u> <u>Aberdeen, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13000

13000

REPORT OF STATE

1. Name of the person or organization		2. Address		3. City		4. State		5. Zip	
6. Title		7. Date		8. Time		9. Location		10. Remarks	
11. Name of the person or organization		12. Address		13. City		14. State		15. Zip	
16. Title		17. Date		18. Time		19. Location		20. Remarks	
21. Name of the person or organization		22. Address		23. City		24. State		25. Zip	
26. Title		27. Date		28. Time		29. Location		30. Remarks	
31. Name of the person or organization		32. Address		33. City		34. State		35. Zip	
36. Title		37. Date		38. Time		39. Location		40. Remarks	
41. Name of the person or organization		42. Address		43. City		44. State		45. Zip	
46. Title		47. Date		48. Time		49. Location		50. Remarks	
51. Name of the person or organization		52. Address		53. City		54. State		55. Zip	
56. Title		57. Date		58. Time		59. Location		60. Remarks	
61. Name of the person or organization		62. Address		63. City		64. State		65. Zip	
66. Title		67. Date		68. Time		69. Location		70. Remarks	
71. Name of the person or organization		72. Address		73. City		74. State		75. Zip	
76. Title		77. Date		78. Time		79. Location		80. Remarks	
81. Name of the person or organization		82. Address		83. City		84. State		85. Zip	
86. Title		87. Date		88. Time		89. Location		90. Remarks	
91. Name of the person or organization		92. Address		93. City		94. State		95. Zip	
96. Title		97. Date		98. Time		99. Location		100. Remarks	



OCT 18 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ABERDEEN PROVING GROUND, MD</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood, Maryland</b>					
c. LENGTH OF STAY IN 1b <b>13 days</b>					d. STREET ADDRESS <b>324 Crestwood Drive</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KIRK ARMY HOSPITAL</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>OSCAR</b> Middle <b>Lee</b> Last <b>TUCKER</b>					4. DATE OF DEATH Month <b>OCT</b> Day <b>10</b> Year <b>1967</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 Feb 1903</b>		9. AGE (In years last birthday) <b>64</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET SOLDIER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US ARMY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Paris, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Floyd L. Tucker</b>					14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Newsome</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WWII</b>					16. SOCIAL SECURITY NO. <b>098-22-7119</b>		17. INFORMANT <b>Gertrud Tucker</b> Address <b>324 Crestwood Dr, Edgewood, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO (b) <b>Lung Carcinoma</b> DUE TO (c) <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>27 SEP</b> , 1967, to <b>10 OCT</b> , 1967, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>10 OCT</b> , 1967, and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.										
22a. SIGNATURE <b>Marvin A. Roth</b>					22b. DATE SIGNED <b>10 Oct 67</b>					
22c. PHYSICIAN'S NAME (Type) <b>MARVIN A. ROTH, CPT, MC</b>					22d. ADDRESS <b>KIRK ARMY HOSPITAL, ABERDEEN PG, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Ft. Myer, Va.</b>			23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md. 21009</b>					25a. REC'D BY REGISTRAR <b>OCT 16 1967</b>					25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>

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ARMY MEDICAL CENTER, 13 Ave

Lawrence, Kansas

KING ARMY HOSPITAL

321 Greenwood Drive

COOPER

TUCKER

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2 Nov 1943

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US ARMY

Paris, France

JOHN J. BAKER

My Elizabeth Newman

Lowellville, Ohio

Long, Indiana

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27 SEP

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10 OCT

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MARVIN A. NORTH, CPT, MC

KING ARMY HOSPITAL, ARBONCK, CT.



13967

## CERTIFICATE OF DEATH

13972

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN lb <u>24 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>728 Old Joppa Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Sharon</u> Middle <u>Lee</u> Last <u>UZZELL</u>		4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 27 1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beech High</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MD Baltimore</u>
13. FATHER'S NAME <u>Vernon Roy Uzzell</u>		14. MOTHER'S MAIDEN NAME <u>Helene Lozak Joppa MD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-58-1380</u>	17. INFORMANT <u>Vernon Uzzell</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lungs Hemorrhage</u> DUE TO (b) <u>Acute Leukemia</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>11 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 4</u> , 19 <u>67</u> , to <u>Oct. 28</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Oct. 28</u> 19 <u>67</u> , and that death occurred at <u>12 40</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>10/28/67</u>	22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>
24. BURIAL DIRECTOR <u>W. Starcher</u>		25a. REC'D BY REGISTRAR <u>Benson MD</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>		25c. DATE <u>OCT 31 1967</u>	



## CERTIFICATE OF DEATH

13973

13968

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1329 Bynum Ridge Rd</u>		d. STREET ADDRESS <u>FOREST HILL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Boy</u> First Middle Last		4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-67</u>
9. AGE (In years lost birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>5</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Harford</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Mae Vaughn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>7735</u>	
17. INFORMANT (Hospital Records) <u>Shirley M. Vaughn</u> Address <u>1329 Bynum Ridge Rd. Forest Hill, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> DUE TO <u>Hyaline membrane disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Prematurity</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>Dr.</u> (this hospital) attended the deceased from <u>10-1-</u> , 19 <u>67</u> , to <u>10-5</u> , 1967, that <u>(H)</u> (we) last saw the deceased alive on <u>10-5</u> , 1967, and that death occurred at <u>9:05 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>H. Brenner</u>		22b. DATE SIGNED <u>10-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. BRENNER</u>		22d. ADDRESS <u>419 S. UNION AVE. HAVER DE GRACE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>October 7, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Harford Co., Md. 21014</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR <u>OCT 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1941

UNITED STATES OF AMERICA

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Not Known

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## 13969

VR A15 (4)  
20 M 1/66

1. PLACE OF DEATH a. COUNTY <b>HARTFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood - Rural</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood - Rural</b>		<b>12-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>none</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MABEL</b>		First <b>ISABELLE</b>		Middle <b>WATTERS</b>		Last	
4. DATE OF DEATH <b>October 13 1967</b>		Month		Day		Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 2, 1919</b>	
9. AGE (In years last birthday) yrs. <b>48</b>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Alice Watters</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-28-0593</b>		17. INFORMANT <b>Elsie Mae Demby, 2066 Battle St., Edgewood Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>arterial sclerotic heart disease with</b> (b) <b>hypertension and Diabetes</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>hemiplegia 1 month ago</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-10</b> , 1965, to <b>10-13</b> , 1967, that (I) (we) last saw the deceased alive on <b>10-12</b> , 1967, and that death occurred at <b>11A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Fred O. Hodous</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Oct. 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Fred O. Hodous, M.D.</b>				22d. ADDRESS <b>Edgewood, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Community Baptist Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Joppa Harford Md</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





VR A15 (4)  
15M 4-64

1. PLACE OF DEATH a. COUNTY <u>Harford</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Benson</u>		c. LENGTH OF STAY IN 1b <u>27 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>at Home</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Francis Weaver</u>		4. DATE OF DEATH <u>October 14 1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>		8. DATE OF BIRTH <u>Apr 30 1884</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md. U.S.</u>	
13. FATHER'S NAME <u>Edward Ligan</u>		14. MOTHER'S MAIDEN NAME <u>Anna Mary Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Margaret Weaver</u>		Address <u>Benson Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u> <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1960, to <u>Oct 14</u> , 1967, that (I) (we) last saw the deceased alive on <u>Oct 12</u> , 1967, and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Fred O. Hodous</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Fred O. Hodous</u>		22d. ADDRESS <u>Edgewood, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 15, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Johns Catholic</u>		23d. LOCATION (City, town or county) (State) <u>Long Green Md</u>	
24. FUNERAL DIRECTOR <u>W. H. Archer</u>		25a. REC'D BY REGISTRAR <u>Oct 17 1967</u>	
ADDRESS <u>Benson Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
GM 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13971

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13976

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>			d. STREET ADDRESS <b>Route #3, Box 35--A.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ARCHIE</b> Middle <b>J.</b> Last <b>WILEY</b>			4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 Sept. 1916</b>		9. AGE (In years last birthday) yrs. <b>51</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>John Marion Wiley</b>		
14. MOTHER'S MAIDEN NAME <b>Amy E. Ferrell</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Current</b>		
16. SOCIAL SECURITY NO. <b>235-18-9088</b>		17. INFORMANT <b>Idse Wiley, Aberdeen, Maryland.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Open fracture of skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto--Train accident.</b>			
20c. TIME OF INJURY Month, Day, Year <b>1:30 p.m. Oct. 14 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, etc.) <b>Bel Air, Md.</b>		20f. (City or town) (County) (State) <b>Aberdeen-Har. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Gerald C Palmer</b>		M.D. <b>Gerald C. Palmer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Bel Air, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-17-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harford Memorial Gardens</b>	
24. FUNERAL DIRECTOR <b>Lee A. Patterson &amp; Son, Perryville, Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Aberdeen Md. Rural</b>		25a. REC'D BY REGISTRAR <b>OCT 23 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles George</b>	

James C. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13972

13977

1. PLACE OF DEATH a. COUNTY <u>Harrison</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrison</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harrison Memorial Hosp. Bldg.</u>		d. STREET ADDRESS <u>Rt 222</u>	
3. NAME OF DECEASED (Type or print) <u>Henrietta A. Williams</u>		4. DATE OF DEATH <u>October 29 1967</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-28-32</u>	
9. AGE (In years lost birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Williams</u>		14. MOTHER'S MAIDEN NAME <u>Margretta Pitts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-6012</u>	
17. INFORMANT <u>Mrs. Margretta Williams, Port Deposit, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7545 Congenital Heart Disease</u> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>10-30-67</u>	
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Meth. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Cecil Md.</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson &amp; Son, Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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13972

## CERTIFICATE OF DEATH

13978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>		c. LENGTH OF STAY IN 1b <b>26 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>none</b>				d. STREET ADDRESS <b>1911 Hanson Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SHIRLEY</b> Middle <b>MASON</b> Last <b>WILLIAMS</b>				4. DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1908</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>24</b> Days <b>19</b> Hours <b>67</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Charleston, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>228-10-2076</b>		17. INFORMANT <b>Lynnwood A. Williams</b> Address <b>Edgewood, Md.</b> <b>1911 Hanson Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> 443X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Urinary Retention</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from <b>1963</b> , to <b>10/24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9/23</b> 19 <b>67</b> , and that death occurred at <b>7:30 AM</b> , from causes on and on the date stated above.							
22a. SIGNATURE <b>E. Louis Kahan, M.D.</b>				22b. DATE SIGNED <b>Oct. 24, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>E. Louis Kahan, M.D.</b>	
22d. ADDRESS <b>Edgewood, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>Oct. 25, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>A.W. Bennett Funeral Home</b>		23d. LOCATION (City or Town) (County) (State) <b>Richmond VA.</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 26 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles George</b>	



13974

CERTIFICATE OF DEATH

13979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun, Rural</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>R.D.#2</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ira Richmond Wilson</u>		f. DATE OF DEATH <u>10-25-1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>5-28-1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Fireman U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>	9. AGE (In years last birthday) yrs. <u>56</u>
13. FATHER'S NAME <u>Ira Richmond Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Sara Morris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>203-07-1526</u>	
17. INFORMANT <u>Mrs. Ira Wilson</u>		Address <u>Rising Sun, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis from</u> <u>151X</u> DUE TO <u>gastric Ca</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-24, 1967</u> to <u>10-25, 1967</u> , that (I) (we) last saw the deceased alive on <u>10-25, 1967</u> , and that death occurred at <u>7:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>H. Kwan</u>		22b. DATE SIGNED <u>10/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY H. KWAN</u>		22d. ADDRESS <u>608 S. Union Ave, Harford</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Conowingo Baptist Conowingo</u>	23d. LOCATION (City or Town) (County) (State) <u>Cecil Md.</u>
24. FUNERAL DIRECTOR <u>Edmond M. Haller</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Rising Sun, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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